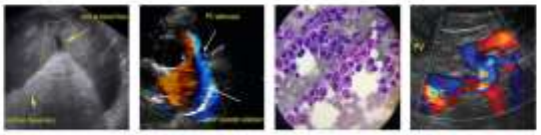


PATIENT

Waddles Monn

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

2010

WEIGHT

6

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME

Blue Ridge VC

REFERRING VET

Dr. Shelly

INVOICE

13460

DATE

3/9/22

PRESENTING CLINICAL SIGNS

6 month duration weight loss, jaundice, palpable cranial abdominal mass

ALP 610, ALT 107, TBili 18.2, HCT 23, WBC 19.6 with Neutrophilia and Monocytosis

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Moderate, nondependent, particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.6 cm in length. The right kidney measured 3.9 cm in length.

Adrenal Glands

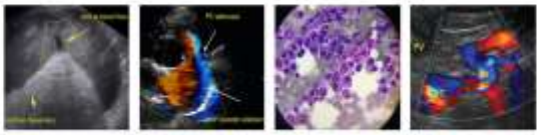
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.36 cm width. No overt pathology was noted in the area of the right adrenal gland, although not definitively visualized.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/ Gallbladder

The liver exhibited mild generalized enlargement and diffuse mild Increased hepatic parenchyma echogenicity with moderate coarse echotexture. Generalized moderate to marked biliary tree dilation was present. The gallbladder was distended in appearance with mildly prominent isoechoic to mildly echogenic walls. Anechoic content with moderate, nonorganized mucus was present in the gallbladder extending into the dilated cystic biliary duct. Generalized variable yet primarily severe common bile duct distention containing anechoic content with mild mucoduct extending caudally into the area of the duodenal papilla was present. The common bile duct dilation measured 1.1 cm diameter in the mid to distal common bile duct.



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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

Small pockets of scant peritoneal, primarily perihepatic free fluid were present.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy exhibiting generalized moderate to marked biliary tree dilation
- Distended gallbladder containing moderate mucus, suspect mild chronic cholecystitis
- Generalized variable yet severe common bile duct distention with mild mucoduct
- Chronic active pancreatitis
- Scant primarily perihepatic free fluid
- Moderate urinary bladder sediment - likely cellular to crystalline debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hepatobiliary presentation in this patient is consistent with chronic post-hepatic obstruction. A definitive cause of the obstruction such as overt calculi, mucus plug, or definitive mass was not evident, yet these possibilities as potential causes of post-hepatic obstruction cannot be definitively excluded. Potential for some degree of post hepatic obstruction owing to pancreatitis could also be possible. The palpable reported cranial abdominal mass may correlate with hepatomegaly or potential caudal position for the gallbladder.

Further assessment with CT could be considered prior to surgical considerations. However, given these findings, exploratory laparotomy for gross inspection of the common bile duct, area of the common bile duct, area of the duodenal papilla, potential for common bile duct redirection technique, bile culture and sensitivity, as well as hepatic parenchymal biopsies for histopathology +/- tissue culture and sensitivity is warranted. Coagulation panel is recommended prior to potential surgery.

Empirically, aggressive cholangiohepatitis / cholangitis and chronic active pancreatitis therapy with as-needed gastrointestinal support and close monitoring of hepatobiliary response would be a more conservative approach.

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

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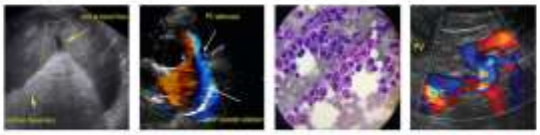

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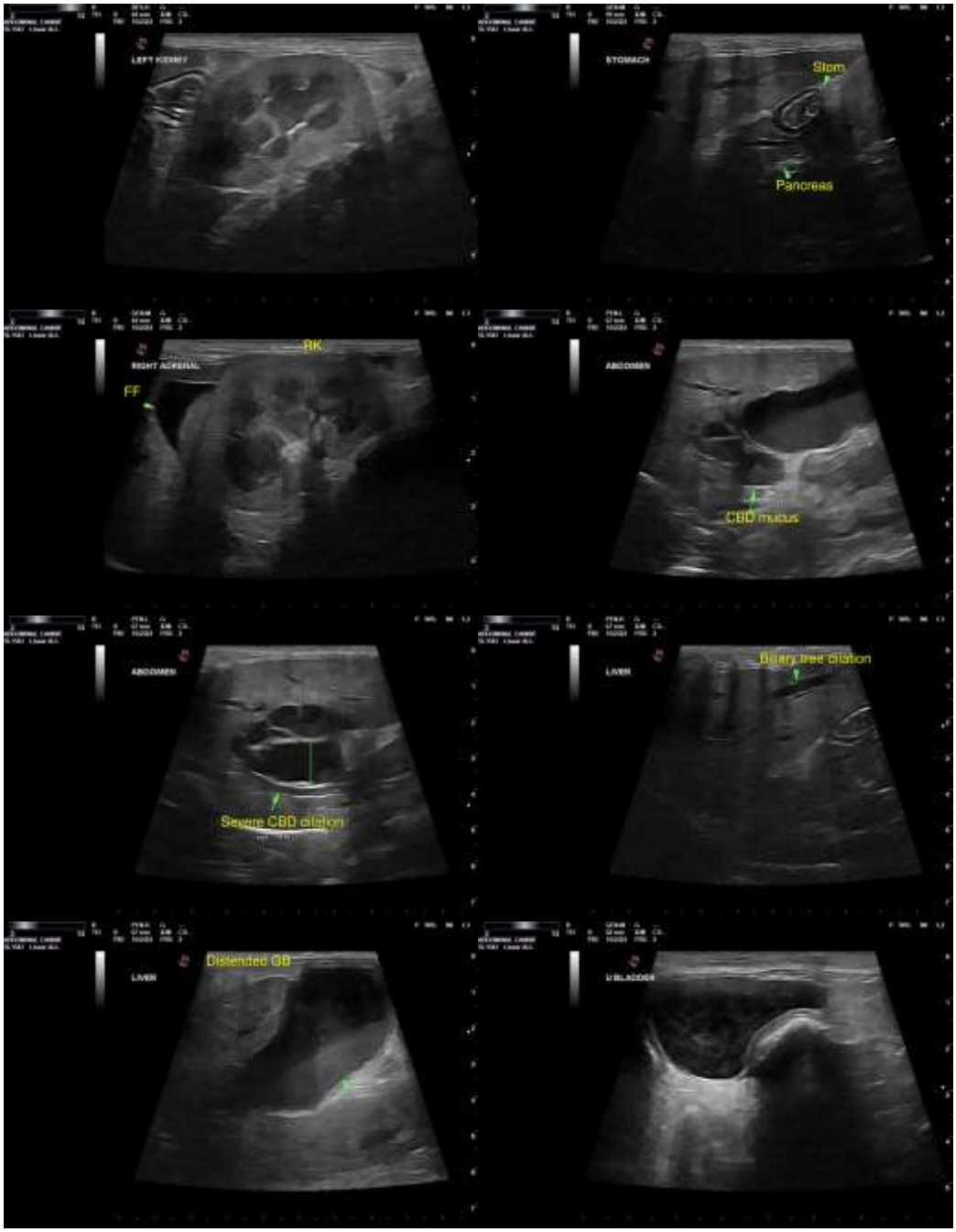

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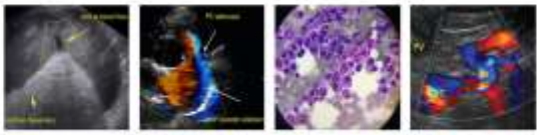

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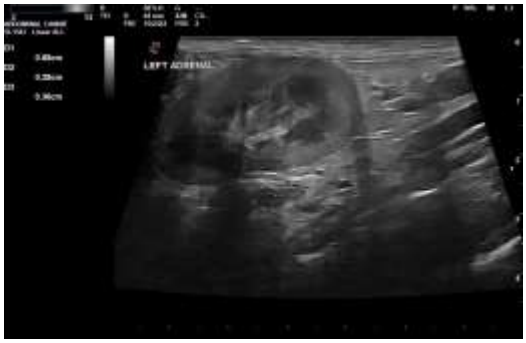

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
mac.daniel@sonopath.com